State of Illinois
Department of Employment Security
www.ides.state.il.us

Interstate Request for Reconsideration of Monetary Determination/Wage Credits

(Este es un documento importante. Si usted necesita un intérprete, póngase en contacto con su oficina local.)

Section A: Personal Information	Print
1. Claimant's Name: (First, Middle, Last)	4. Social Security Number:
Name worker under, if different:	Other Social Security Number, if any:
2. Local Mailing Address: Street: (Apt/Unit/Suite/etc.): City: State: Zip:	5. Liable State: 6. Transferring State: Program: 7. ☐ UI ☐ UCFE ☐ UCX ☐ CWC
3. PHONE NUMBER: ex.((000) 000-0000) ( ) -	
8. I request reconsideration of my monetary determination dated: I request reconsideration of my week/wages transferred (IB-4). (Provide reason(s) below, use additional sheet if needed):	

9. If you disagree with the determined amount of base period wages or weeks, complete Section B:

Section B: Wages (Attach Any Supporting Documents Such As Check Stubs Or W-2 Forms)

Base Period Quarter Ending / YR	Wages	Weeks	Employer Name	Dates Worked From	Dates Worked Through
March 31 /	$				
June 30 /	$				
Sept. 30 /	$				
Dec. 31 /	$				

10. Complete Section C: Employer Information, for any base period employer not listed on the determination:

Section C: Employer Information (Attach Any Supporting Documents Such As Check Stubs Or W-2 Forms)

Employer Name:	From (Dates Worked) Through
Address Street: (Apt/Unit/Suite/etc.): City: State: Zip:	Gross Wages $
Payroll Address (if different) Street: (Apt./Unit/Suite/etc.): City: State: Zip:	

Type of Work Performed	Clock or Badge Number	Number of Employees

Note: If Number 9 Section B or 10 Section C is completed, attach any supporting documents, such as check stubs or W2 Forms.

Section D: Signature 11. The above facts are true to the best of my knowledge and belief.
Claimant's Signature:

Local Office Use Only:
12. Request Filed: In Person (Date) By Mail (Date) Received (Date)
13. I certify that I have verified the claimant's social security Number.
Claims Taker's Signature: Local Office #:
LOFF Address:
Phone: Fax: TTY:
Distribution: * Original and one (1) copy to Liable State/Transferring State * Copy to Claimant * Copy to Agent State File
If employer was not listed on IB-1, obtain reason for separation on IB-11, if required by Handbook.

Print